# THE PATIENTS' NEEDS AND THE CHANGING ROLE OF HEALTH MANPOWER: A VIEW FROM THE DR. MARTIN LUTHER KING JR. HEALTH CENTER*

EDWARD D. MARTIN, M.D.

Director of Health Services
Dr. Martin Luther King Jr. Health Center
Bronx, N.Y.

THE term "situational needs" describes most precisely the purpose as well as the clear limitations and major differences of the minisystem I have been asked to discuss. I shall focus on describing the Dr. Martin Luther King Jr. Health Center and our specific experiences there as we have gone through significant changes in the roles of health professionals as they face the overwhelming needs of our patients. I might add that we have some advantage in creating new systems in the southeast Bronx—few people chose to come to scrutinize the area and neither traditional academicians nor medical politicians have come to stake out a territorial claim.

The Dr. Martin Luther King Jr. Health Center was originally funded by the Office of Economic Opportunity (OEO) in July 1966 as a Medical Care Demonstration Project through Montefiore Hospital. The Health Center serves an area covering some 67 square blocks in a low-income area in the southeast Bronx. Approximately 10,000 families (45,000 people) live in the area; this population is equally divided between black and Puerto Rican families, with about 4% white.

The area is blighted with empty and burned out apartment buildings, run-down factory buildings, and garbage-strewn streets and lots. The "social statistics" reflect what the eye sees: there is a high unemployment rate, about half the families are on public assistance, housing is inadequate and crowded, the crime rates are high, and hard-drug use is endemic.

Prior to the advent of the Martin Luther King Health Center, the

*Presented at a meeting on *The Patient's Needs and the Changing Role of Health Manpower* sponsored by the Committee on Medicine in Society of the New York Academy of Medicine, February 24, 1972.

vast majority of people in this neighborhood had received their medical care from the clinics and emergency rooms of hospitals, from a few practitioners in adjacent areas, from pharmacists and faith healers or, in many cases, not any. Continuity, follow-up, and preventive care were unknown, accessability and availability were major problems, and the infant mortality and tuberculosis-incidence rate reflected what was clearly a totally inadequate health care system in the area.

Dr. Harold Wise and his staff developed the Health Center against this background. The perceived needs as well as the articulated demands of this community provided many of the parameters for the roles that have evolved.

Continuing family care was developed through health teams which were responsible for a defined geographical area and panel of families. The teams included an internist, a pediatrician, two public health nurses, and five or six family health workers. The family health worker, a trained community resident, incorporated into her role some of the functions of the public health nurses, the social worker, the health educator, and the legal advocate. The primary responsibility of this functionary has evolved into that of the team practitioner who has clear overall responsibility for the continuity, follow-up, and coordination of care for a group of 150 to 200 families. This responsibility is essential in order that the team may provide a continuous, regular, and sensitive professional to deal with the broad scope of needs faced by the majority of the King Center families.

The public health nurse's role has evolved into that of a nurse-practitioner on the team. Her responsibilities now include primary maternal and well-child care for a growing number of the patients of her team in addition to her role as a community-health nursing resource to the patients and the team.

At present the eight health teams are supported by a dental unit, with 10 full-time dentists, a broadly-based specialty consultation unit which utilizes part-time specialists, a small community mental health division, and appropriate allied health services such as laboratory, x ray, medical records, and transportation.

In addition, there is a Department of Community Health Advocacy, or Community Development, staffed by lawyers and community residents with special training and considerable knowledge about welfare, schools, housing, sanitation, and the multiplicity of related issues which

figure so heavily in the over-all health considerations of the community. This staff serves to support team efforts in these health-related areas and to develop programmatic approaches toward maintaining and improving the environmental status of this rapidly degenerating area.

We have had a strong feeling at the Health Center that the system of care provided at the center should relate squarely to the needs of the community it serves. We feel further that the roles of the health workers should be created and developed in this context.

An important mission of the Health Center has been to train and develop health workers from the community surrounding the Health Center—a mission which relates not only to the desperate need for gainful employment in the area but deals with the need for health workers sensitive to and knowledgeable of the major problems (social, economic, and cultural) of this particular community. Further, the emotion-laden but nonetheless fundamental issues of self-determination for black and Puerto Rican health workers and community control of its own health center continue to be major forces in the development of systems, especially management systems. This concern has resulted, although not without problems, in the development of a neighborhood health center with an overwhelming predominance of black and Puerto Rican health workers in roles at all levels (administrative, clerical, professional, and technical) with the significant exception of physicians, although this is beginning to change as well. An important point is that recognition of the unavailability of minority physicians, coupled with the realization that most physician functions, except technical medical care, can be done as well or better by other health professionals has proved to be one of the stronger forces in the expansion of the roles of other health professionals at the center.

A rough breakdown of the Health Center staff reveals an unusually high percentage of allied health professionals to physicians. We have about 30 physicians and 11 dentist equivalents in a health services staff of about 360 for a ratio of 8:1. In the primary-care areas, which excludes the health services administrative and allied health services supportive staff (laboratory, medical records, etc.) the ratio is about 4:1. If one considers the teams alone, there are 18 physicians, 16 nurse practitioners, and 48 family health workers—roughly one pediatrician or internist for every nurse and three family health workers.

It is important to point out that we have experienced major difficul-

ties in moving toward the expansion of new roles for health workers. The major difficulty has been the reluctance of individuals and professional groups to accept not only their own evolving roles but the changing roles of fellow professionals. Ingrained professional chauvinism and acute sensitivities about territorial imperatives have resulted in major difficulties manifest in such issues as supervision, control, who will evaluate whom, what is a medical or nursing decision, who serves on committees, and so forth. There was considerable resistance, now measurably eroded, to the development of a setting where professionals saw each other as co-workers rather than subprofessionals or supervisors.

In part, these professional resistances were reinforced by the insecurity of newly trained community workers who were sensitive about their lack of credentials and prone to fall into traditional dependency-patient roles. There was and continues to be the issue of paternalism, especially by conscientious white professionals, but this is being modified by more aggressive and articulate moves made by new health workers, which result in more frank and healthy relations. There was and continues to be difficulty about which tasks are going to be relinquished and a clear tendency to dump unwanted tasks on new health workers. This has had to be met with clear definitions about the needs of patients and priorities, personnel resources, and then decisions about who can best do a given task. The training process, especially on-going in-service training, has been a problem since there has been much apprehension about who should learn which tasks. This has been further complicated by the fact that curricula prepared by other professionals often were merely agendas for one professional group, which then called upon other professional groups to assist and teach in specific areas.

Roles and role-perceptions were also tied to many of the day-to-day systems problems (appointments, laboratory reports, charts, etc.) that have plagued the Health Center for years. This resulted often in compromising important objectives to satisfy urgent problems.

Finally, there was much confusion about staff and line functions in the agency and, as in most traditional health systems, this resulted in the assumption that professional expertise, held mostly by the physicians and nurses, was linked to management ability. Thus the supervisors were vertically related to the teams in the traditionally separate guild models, and the line authority was largely held by a small group of noncom-

munity professionals. The problem has been solved largely by separating professional supervision (audit, etc.) from line management of units, sections, and division. This allowed for the movement of a large number of talented black and Puerto Rican health workers into positions of supervisory and middle-management responsibility. At this time, of 17 line managers in the Department of Health Services, only the pharmacy supervisor and myself are not black or Puerto Rican. The professional supervisors still are active participants in planning and quality of care audit but have relinquished almost all administrative responsibilities—which now they feel retrospectively was a good move since they spend more time in areas of their real interest and expertise such as audit, training, and the care of patients.

Exogenous factors which generate problems include restrictive financing mechanisms which tend to perpetuate expensive physician-oriented care by not reimbursing nurse practitioners, physician associates, or even home visits. Obstructive accreditation procedures, pathetically out of date but fortified at every turn by specialism and by territorial defensive moves further discourage innovative approaches or the development of new roles. These restrictive forces weigh less heavily on a center such as ours at this time than on established hospitals and university centers but will slow advances in the future as we attempt to utilize new professionals in expanded roles without having had them undergo protracted, many times irrelevant, formal academic training.

The question of costs is a major concern to the Health Center at this time. During the initial years of training, of construction and equipping, and of developing what is a relatively unique system for health care delivery—the costs were quite high—with estimates running as high as $60 or more for a visit made by a patient. Even with a significant amount of wastage and replication born largely of inexperience and experimentation, the cost was predictably high during the period and analogous to "start-up" costs in any comparable public endeavor. However, with the consolidation phase in its second year, costs per visit have dropped toward a realistic figure. Our Medicaid reimbursement rate, based on an audit of 1970 figures, which was prior to the consolidation phase, was $45 per visit and includes all drugs, x rays, related home visits, laboratory, and other support services. These figures are different from those used occasionally in some press accounts which were calculated by a means unknown to us and included a host of unspent monies

and unrelated costs. Actual costs for 1971 did not increase, and physician and dental visits increased from 90,000 to 130,000 for 1971. This does not include 15,000 visits made by nurse practitioners nor an estimated 70,000 home visits made by family health workers and nurses. Although our new Medicaid rate is yet undetermined, it will clearly be decreased.

Our objective, which we feel to be realistic and attainable, is to bring the cost down to close to $32 per practitioner visit by 1973. Given the contributing cost of laboratory, x ray, drug and appliances, and the additional cost accrued in efforts such as full hospital coverage, community health education, and programs directed at problems such as drug abuse, this breaks out to be comparable to most prepaid agencies which have cost control as their primary focus.

It is important to emphasize our strong feelings that there are significant problems in looking at isolated cost-center analyses. We are serving a community with long neglected and overwhelming health problems and assuming responsibility for health problems generated by the oppressing and destructive environment of a deteriorating inner city area. A cost-efficient systems in our area, such as Medicaid clinics or the city hospital emergency rooms, can and do deliver large quantities of ambulatory care at from $20 to $25 per visit, which is inexpensive comparatively. However, this is not cost-*effective*, since the facilities are merely passing on the costs to inpatient facilities and other social agencies by providing nonpreventive, noncontinuous and, in general, low-quality care. Clear examples of the results of this are the institutionalization rates for lead poisoning, mental retardation, birth defects secondary to poor prenatal care, increased needs for public assistance due to poor family planning and increased morbidity from preventable illnesses among children and adults. In regard to cost feasibility and effectiveness, we are convinced our approach is not only both feasible and effective, but more so than systems which are constrained to exclude preventive care from their health approach.

The issue of the role of the consumer or the community in the development of the center, presently and in the future, is really the subject for a separate paper since it is so complex. The importance of community involvement and control is of major importance to a center like ours and is difficult to deal with briefly. So I shall not attempt to summarize consumer and community participation at our center, and I do an injustice by simplification of the issue.

The very general comments cited give a clear indication of the direction we hope to continue respective to the development and expansion of new health roles at the Martin Luther King Center. We see a steady expansion of allied health professional responsibility in providing primary and supportative care. Many of the functions of physicians and even nurses can be carried out by well-trained community residents, thereby freeing physicians and nurse practitioners to reach even more families requiring their specialized and technical skills. For the foreseeable future, this is the main hope for communities such as this one, and certainly the dramatic successes of the Soviets and the Chinese in utilizing health workers to deal with public health problems identical to ours augurs well for our efforts. This will not, I believe, lead to an inferior level of care for communities relying on these new workers in comparison to middle- and upper-income groups. From what I have seen, second-class care may very well be a problem for these areas as well, especially regarding preventive and public health care.

It may be that we shall all be moving to a more broadly based health system and shall be relying far less on the vertical and highly specialized skills of the physician. As a physician I can hardly see that the pediatrician in Westchester is any less poorly utilized doing well-baby examinations and advising mothers on diaper care than pediatricians in the south Bronx. It is predictable that social-policy changes and economic considerations will eventually place the same pressures that we now feel on other areas and that there will be an increasing shift to better utilization and recognition of a broad scope of health workers, especially in ambulatory and community health care.